Anesthesia Payment Policies

This section contains payment policies and information for anesthesia providers. Anesthesia codes and base units are listed in the "CPT & HCPCS Fee Schedule" section.

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules, Provider Bulletins,* and *Provider Updates*. If there are any services, procedures, or text contained in the CPT and HCPCS coding books that are in conflict with the *Medical Aid Rules and Fee Schedules*, the department's rules and policies apply (WAC 296-20-010). All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811.

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ANESTHESIA OVERVIEW

Anesthesia payment policies are established by the department and the Washington Reimbursement Steering Committee (RSC). The RSC is a standing committee with representatives from the Department of Labor and Industries, the Department of Social and Health Services, and the Health Care Authority. The Anesthesia Technical Advisory Group (ATAG), a group which represents Anesthesiologists, Certified Registered Nurse Anesthetists (CRNAs), and administrators, advises the RSC on anesthesia payment policies.

ANESTHESIA FEE SCHEDULE CHANGES

ANESTHESIA BILLING CODES

CPT added two new anesthesia codes in 2001 (CPT 01951 and 01952) which conflict with two American Society of Anesthesiologists (ASA) codes that the department was using. When there are differences in code descriptions between CPT and ASA, providers should bill according to the CPT descriptions.

Codes 01951 and 01952 should be used for burn excisions or debridement and billed according to their CPT descriptions. Anesthesia nerve blocks may now be billed using ASA codes 01961 and 01962.

ANESTHESIA ADD-ON CODE

CPT has created add-on code 01953 to be used in conjunction with 01952. Special billing instructions apply to anesthesia add-on codes. Refer to “Anesthesia Add-On Codes” later in this section for more information.

CPT 01996

Effective January 1, 2001, the department pays for CPT 01996 with a maximum fee rather than with base and time units. Refer to "Anesthesia Services Paid with RBRVS" later in this section for more information.

ANESTHESIA PAYMENT INFORMATION

Anesthesiologists and CRNAs must have valid individual L&I provider account numbers to be paid for services. The department does not cover anesthesia assistant services.

Anesthesia is not payable for procedures that are not covered by the department. Non-covered codes are listed in **Appendix E** of the “Washington RBRVS Payment Policies” section.

Patient acuity does not affect payment levels. Payment for qualifying circumstances (CPT codes 99100, 99116, 99135 and 99140) is considered bundled and is not payable separately. CPT physical status modifiers (-P1 to -P6) and CPT five digit modifiers are not accepted.

Anesthesia by surgeon (modifier -47) is not payable. Payment for local, regional or digital block or general anesthesia administered by the surgeon is considered included in the RBRVS payment for the procedure. These services will not be paid separately. Bills for anesthesia services with modifier -47 will be denied.

MEDICAL DIRECTION OF ANESTHESIA (TEAM CARE)

The department follows HCFA's policy for medical direction of anesthesia, which is the same as "Team Care." Physicians directing qualified individuals performing anesthesia must:

- perform a pre-anesthetic examination and evaluation,
- prescribe the anesthesia plan,
- personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence,
- ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions,
- monitor the course of anesthesia administration at frequent intervals,
- remain physically present and available for immediate diagnosis and treatment of emergencies, and
- provide indicated post-anesthesia care.

In addition, the physician may direct no more than four anesthesia services concurrently and may not perform any other services while directing the single or concurrent services. The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

The physician must document in the patient's medical record that the medical direction requirements were met. The physician does not need to submit this documentation with the bill, but must make the documentation available to the insurer upon request.

Billing Tip

When billing for team care situations, anesthesiologists and CRNAs should submit separate bills under their own provider account numbers. Anesthesiologists billing for team care should use the appropriate modifier for medical direction or supervision (-QK or -QY). CRNAs billing for team care should use modifier -QX. Once the total maximum anesthesia payment is calculated, 50% of that amount may be paid to the physician, and 45% to the CRNA (90% of the other 50% share).

CERTIFIED REGISTERED NURSE ANESTHETISTS

Licensed nursing rules and billing instructions are contained in WACs 296-23-240 and -245. CRNA services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician. The only modifiers that are valid for CRNAs are -QX and -QZ (see "Anesthesia Modifiers" later in this section).

Billing Tip

CRNA services must be billed on a separate HCFA-1500 form from those of an anesthesiologist, since they each have their own modifiers and provider account numbers. This applies to CRNAs providing solo services as well as team care. Further details and examples of how to submit bills can be found in the department's HCFA-1500 billing instructions (publication #F248-094-000).

ANESTHESIA SERVICES PAID WITH BASE AND TIME UNITS

Most anesthesia services are paid with base and time units. The department's anesthesia base units are adapted from HCFA's anesthesia base units with input from the Anesthesia Technical Advisory Group (ATAG). The anesthesia codes and base units are listed in the "CPT and HCPCS Fee Schedule" section.

Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent). Anesthesia time ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e. when the patient can be safely placed under postoperative supervision). Anesthesia should be billed in *one-minute* time units.

Anesthesia services should be billed using CPT anesthesia codes 00100 through 01999 and the appropriate anesthesia modifier (refer to "Anesthesia Modifiers" later in this section). In addition to the CPT anesthesia codes, the department will also accept the following anesthesia codes which are published in the American Society of Anesthesiologists' Relative Value Guide (ASARVG):

ASA Code*	ASA Description*
01961	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider)
01962	Anesthesia for diagnostic or therapeutic nerve blocks and injections- patient in the prone position (when block or injection is performed by a different provider)

The department will not accept any other ASARVG codes that are not included in CPT. All other anesthesia codes should be billed according to the descriptions published in CPT. When there are differences in code descriptions between CPT and ASARVG, providers should bill according to the CPT descriptions.

List only the time *in minutes* on your bill. Do not include the base units. The appropriate base units will be automatically added by our payment system when the bill is processed.

ANESTHESIA PAYMENT CALCULATION

The maximum anesthesia payment rate is based on the base value for the procedure, the time the anesthesia service is administered, and the department's anesthesia conversion factor. The anesthesia conversion factor is published in WAC 296-20-135. For services provided on or after July 1, 2001, the anesthesia conversion factor is $40.50 per 15 minutes ($2.70 per minute).

Providers will be paid either their billed amount or the department's maximum allowed amount, whichever is less. To determine the maximum anesthesia payment for a procedure:

1. Multiply the base units listed in the fee schedule by fifteen.
2. Add that value to the total number of whole minutes.

Multiply the sum of 1 and 2 above by $2.70.

For example:

CPT code 01382, anesth, knee arthroscopy, has 3 anesthesia base units. If the anesthesia service takes 60 minutes, the maximum payment would be calculated as follows:

1. 3 x 15 = 45 base units
2. 45 base units + 60 time units (minutes) = 105 base and time units
3. 105 x $2.70 = $283.50 maximum payment

Billing Tip

When multiple surgical procedures are performed during the same period of anesthesia, only the anesthesia code with the greatest base value should be billed, along with the total time in minutes (except when billing anesthesia add-on codes).

ANESTHESIA ADD-ON CODES

Anesthesia add-on codes should be billed along with a primary anesthesia code. **Do not bill units in minutes for anesthesia add-on codes.** All anesthesia minutes should be billed with the primary anesthesia procedure code.

One anesthesia code, CPT 01953, was designated as an add-on procedure in CPT 2001. The table below explains how to bill for anesthesia for burn excision or debridement using primary procedure codes 01951 and 01952 and anesthesia add-on code 01953.

Total Body Surface Area	**Primary Procedure Code** (bill units in minutes)	**Add-On Code** (bill units as indicated below)
Less than 1 percent	01951	None
1 to 9 percent	01952	None
Up to 18 percent	01952	1 unit of 01953
Up to 27 percent	01952	2 units of 01953
Up to 36 percent	01952	3 units of 01953
Up to 45 percent	01952	4 units of 01953
Up to 54 percent	01952	5 units of 01953
Up to 63 percent	01952	6 units of 01953
Up to 72 percent	01952	7 units of 01953
Up to 81 percent	01952	8 units of 01953
Up to 90 percent	01952	9 units of 01953
Up to 99 percent	01952	10 units of 01953

ANESTHESIA SERVICES PAID WITH RBRVS

Some services commonly performed by anesthesiologists and CRNAs are *not* paid with anesthesia base and time units. These services include CPT 01996, most pain management services and other selected services. These services are paid with the Washington RBRVS fee schedule and are listed in the appendix at the end of this section.

No anesthesia modifiers should be used when billing for services payable under RBRVS; if an anesthesia modifier is used, the payment for that code will be denied. Payment rates for codes payable under RBRVS are located in the "CPT & HCPCS Fee Schedule" section.

Billing Tip

When services are billed under RBRVS, the total number of times the procedure is performed, not the total minutes, should be entered in the "Units" column (field 24G) on the HCFA-1500 bill form.

EVALUATION AND MANAGEMENT SERVICES PAYABLE WITH PAIN MANAGEMENT PROCEDURES

An E/M service is payable on the same day as a pain management procedure *only when*:

- it is the patient's *initial visit* to the practitioner who is performing the procedure, *or*
- the E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action. The use of E/M codes on days after the procedure is performed is subject to the global surgery policy (see "Washington RBRVS Payment Policies" section).

See the **appendix** at the end of this section for the list of pain management codes.

INJECTION CODE TREATMENT LIMITS

Details regarding treatment guidelines and limits for the following kinds of injections can also be found in WAC 296-20-03001. Refer to "Medication Administration" in the "Washington RBRVS Payment Policies" section for information on billing for medications.

Injection	**Treatment Limit**
Epidural and caudal injections of substances other than anesthetic or contrast solution	*Maximum of six* injections per acute episode is allowed.
Facet injections	*Maximum of four* injection procedures per patient is allowed.
Intramuscular and trigger point injections of steroids and other non-scheduled medications and trigger point *dry needling**	*Maximum of six* injections per patient is allowed.

* *Dry needling* is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. The department does not cover acupuncture services (WAC 296-20-03002). Dry needling of trigger points should be billed using the trigger point injection code 20550. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001 (14).

ANESTHESIA MODIFIERS

Only the modifiers that affect payment are listed in this section. The five digit modifiers listed in CPT, and physical status modifiers (-P1 through -P6) *will not be paid*. For RBRVS modifiers, refer to "RBRVS Modifiers" in the "Washington RBRVS Payment Policies" section. Refer to the CPT and HCPCS books for complete modifier descriptions and instructions.

CPT MODIFIERS

-23 Unusual anesthesia
Applies only to services billed with base and time units. Services billed with this modifier may be individually reviewed prior to payment. Supporting documentation is required for this review.

-99 Multiple modifiers
This modifier should only be used when two or more modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes, only enter modifier -99 in the modifier column. List the individual descriptive modifiers elsewhere on the billing document.

HCPCS MODIFIERS

Physician Modifiers

-AA Anesthesia services performed personally by anesthesiologist
Payment will be made to the physician using the base and time units. Time is billed in total minutes.

-QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
Only physicians may use this modifier. Payment will be based on the policies for team services.

-QY Medical direction of one CRNA for a single anesthesia procedure
Only physicians may use this modifier. Payment will be based on the policies for team services.

CRNA Modifiers

-QX CRNA service: with medical direction by a physician
Only CRNAs may use this modifier. Payment will be based on the policies for team services.

-QZ CRNA service: without medical direction by a physician
Only CRNAs may use this modifier. Payment will be made at 90% of the allowed fee that would otherwise be paid to a physician.

APPENDIX
ANESTHESIA SERVICES PAID WITH RBRVS

Do not rely solely on the descriptions given in the appendices for complete coding information. Please refer to a current CPT book for complete coding information.

PAIN MANAGEMENT CODES

CPT Code	Abbreviated Description
01996	Manage daily drug therapy
20550	Inject tendon/ligament/cyst
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20610	Drain/inject, joint/bursa
27096	Inject sacroiliac joint
61790	Treat trigeminal nerve
62263	Lysis epidural adhesions
62270	Spinal fluid tap, diagnostic
62272	Drain spinal fluid
62273	Treat epidural spine lesion
62281	Treat spinal cord lesion
62282	Treat spinal canal lesion
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
62310	Inject spine c/t
62311	Inject spine l/s (cd)
62318	Inject spine w/cath, c/t
62319	Inject spine w/cath l/s (cd)
63600	Remove spinal cord lesion
64400	Injection for nerve block
64402	Injection for nerve block
64405	Injection for nerve block
64408	Injection for nerve block
64410	Injection for nerve block
64412	Injection for nerve block
64413	Injection for nerve block
64415	Injection for nerve block
64417	Injection for nerve block
64418	Injection for nerve block
64420	Injection for nerve block
64421	Injection for nerve block
64425	Injection for nerve block
64430	Injection for nerve block
64435	Injection for nerve block
64445	Injection for nerve block

CPT Code	Abbreviated Description
64450	Injection for nerve block
64470	Inj paravertebral c/t
64472	Inj paravertebral c/t add-on
64475	Inj paravertebral l/s
64476	Inj paravertebral l/s add-on
64479	Inj foramen epidural c/t
64480	Inj foramen epidural add-on
64483	Inj foramen epidural l/s
64484	Inj foramen epidural add-on
64505	Injection for nerve block
64508	Injection for nerve block
64510	Injection for nerve block
64520	Injection for nerve block
64530	Injection for nerve block
64550	Apply neurostimulator
64553	Implant neuroelectrodes
64555	Implant neuroelectrodes
64560	Implant neuroelectrodes
64565	Implant neuroelectrodes
64573	Implant neuroelectrodes
64575	Implant neuroelectrodes
64577	Implant neuroelectrodes
64580	Implant neuroelectrodes
64585	Revise/remove neuroelectrode
64590	Implant neuroreceiver
64595	Revise/remove neuroreceiver
64600	Injection treatment of nerve
64605	Injection treatment of nerve
64610	Injection treatment of nerve
64612	Destroy nerve, face muscle
64613	Destroy nerve, spine muscle
64620	Injection treatment of nerve
64622	Destr paravertebrl nerve l/s
64623	Destr paravertebral n add-on
64626	Destr paravertebri nerve c/t
64627	Destr paravertebral n add-on
64630	Injection treatment of nerve

CPT Code	Abbreviated Description
64640	Injection treatment of nerve
64680	Injection treatment of nerve
64802	Remove sympathetic nerves
64804	Remove sympathetic nerves
64809	Remove sympathetic nerves
64818	Remove sympathetic nerves

OTHER ACCEPTED CODES

CPT Code	Abbreviated Description
31500	Insert emergency airway
36425	Establish access to vein
36489	Insertion of catheter, vein
36491	Insertion of catheter, vein
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
76000	Fluoroscope examination
76003	Fluoroscope exam, extensive
76005	Fluoroguide for spine inject
93503	Insert/place heart catheter